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CHAPTER X
PATHOLOGY LABORATORY SERVICES
CPT CODES 80000 - 89999
FOR
NATIONAL CORRECT CODING POLICY MANUAL
FOR PART B MEDICARE CARRIERS

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Chapter X
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CPT Codes 80000 - 89999

A. Introduction

Pathology and laboratory CPT coding includes services primarily reported to evaluate specimens obtained from patients (body fluids, cytological specimens, or tissue specimens obtained by invasive/surgical procedures) in order to provide information to the treating physician. This information, coupled with information obtained from history and examination findings and other data, provides the physician with the background upon which medical decision making is established.

Generally, pathology and laboratory specimens are prepared and/or screened by laboratory personnel with a pathologist assuming responsibility for the integrity of the results generated by the laboratory. Certain types of specimens and tests are reviewed personally by the pathologist. CPT coding for this section includes few codes requiring patient contact or evaluation and management services rendered directly by the pathologist. On the occasion that a pathologist provides evaluation and management services (significant, separately identifiable, patient care services that satisfy the criteria set forth in the E & M guidelines developed by CMS, formerly HCFA, and the AMA), appropriate coding should be rendered from the evaluation and management section of the *CPT Manual*.

If, after a test is ordered and performed, additional related procedures are necessary to provide or confirm the result, these would be considered part of the ordered test. For example, if a patient with leukemia has a thrombocytopenia, and a manual platelet count (CPT code 85032) is performed in addition to the performance of an automated hemogram with automated platelet count (CPT code 85025), it would be inappropriate to report CPT codes 85032 and 85025 because the former provides a confirmatory test for the automated hemogram and platelet count (CPT code 85025). As another example, if a patient has an abnormal test result and repeat performance of the test is done to verify the result, the test is reported as one unit of service rather than two.

B. Organ or Disease Oriented Panels

The *CPT Manual* assigns CPT codes to organ or disease oriented panels consisting of a group of specified tests. If all tests of a CPT defined panel are performed, the provider may bill the panel code or the individual component test codes. The panel codes may be used when the tests are ordered as that panel or if the individual component tests of a panel are ordered separately. For example, if the individually ordered tests are cholesterol (CPT code 82465), triglycerides (CPT code 84478), and HDL cholesterol (CPT code 83718), the service could be billed as a lipid panel (CPT code 80061).

C. Evocative/Suppression Testing

Evocative/suppression testing involves administration of agents to determine a patient's response to those agents (CPT codes 80400-80440 are to be used for reporting the laboratory components of the testing). When the test requires physician administration of the evocative/suppression agent as described by CPT codes 90780-90784 (therapeutic/diagnostic injections/infusions), these codes can be separately reported. However, when physician attendance is not required, and the agent is administered by ancillary personnel, these codes are not to be separately reported. In the inpatient setting, these codes are only reported if the physician performs the service personally. In the office setting, the service can be reported when performed by office personnel if the physician is directly supervising the service. While supplies necessary to perform the testing are included in the testing, the appropriate HCPCS J codes for the drugs can be separately reported for the diagnostic agents. Separate evaluation and management services are not to be reported, including prolonged services (in the case of prolonged infusions) unless a significant, separately identifiable service is provided and documented. If separate evaluation and management services are provided and reported, the injection procedure is included in this service and is not separately reported.

D. General Policy Statements

1. Multiple CPT codes are descriptive of services performed for bone and bone marrow evaluation. When a biopsy is performed for evaluation of bone matrix structure, the appropriate code to bill is CPT code 20220 for the biopsy and CPT code 88307 for the surgical pathology evaluation.

When a bone marrow aspiration is performed alone, the appropriate coding is CPT code 38220. Appropriate coding for the interpretation is CPT code 85097 when the only service provided is the interpretation of the bone marrow smear. When both are performed by the same provider, both CPT codes may be reported. The pathological interpretations (CPT code 88300-88309) are not reported in addition to CPT code 85097 unless separate specimens are processed.

When it is medically necessary to evaluate both bone structure and bone marrow, and both services can be provided with one biopsy, only one code (CPT code 38221 or CPT code 20220) can be reported. If two separate biopsies are necessary, then both can be reported using the -59 modifier on one of the codes. Pathological interpretation codes 88300-88309 may be separately reported for multiple separately submitted specimens. If only one specimen is submitted, only one code can be reported regardless of whether the report includes evaluation of both bone structure and bone marrow morphology or not.

2. The family of CPT codes 87040-87158 refers to microbial culture studies. The type of culture is coded to the highest level of specificity regarding source, type, etc. When a culture is processed by a commercial kit, report the code that describes the test to its highest level of specificity. A screening culture and culture for definitive identification are not performed on the same day on the same specimen and therefore are not reported together.

3. When cytopathology codes are reported, the appropriate CPT code to bill is that which describes, to the highest level of specificity, what services were rendered. Accordingly, for a given specimen, only one code from a group of related codes describing a group of services that could be performed on a specimen with the same end result (e.g. 88104-88108, 88142-88143, 88150-88154, 88164-88167, etc.) is to be reported. If multiple services (i.e., separate specimens) are reported, the -59 modifier should be used to indicate that different levels of service were provided for different specimens. This should be reflected in the cytopathologic reports. A cytopathology preparation from a fluid, washing, or brushing is to be reported using one code from the range of CPT codes 88104-88108. It is inappropriate to additionally use CPT codes 88160-88162 because the smears are included in the codes referable to fluids (washings or brushings) and 88160-88162 references “any other source” which would exclude fluids, washings, or brushings.

4. The CPT codes 80500 and 80502 are used to indicate that a pathologist has reviewed and interpreted, with a subsequent written report, a clinical pathology test. These codes additionally are not to be used with any other pathology service that includes a physician interpretation (e.g. surgical pathology). If an evaluation and management service (face-to-face contact with the patient) takes place by the pathologist, then the appropriate E & M code is reported, rather than the clinical pathology consultation codes, even if, as part of the evaluation and management service, review of the test result is performed. Reporting of these services (CPT codes 80500 and 80502) requires the written order for consultation by a treating physician.

5. The CPT codes 88321-88325 are to be used to review slides, tissues, or other material obtained and prepared at a different location and referred to a pathologist for a second opinion. (These codes should not be reported by pathologists reporting a second opinion on slides, tissue, or material also examined and reported by another pathologist in the same provider group.) Medicare generally does not pay twice for an interpretation of a given technical service (e.g., EKGs, radiographs, etc.). When reporting CPT codes 88321-88325, providers should not report other pathology CPT codes such as 88312, 88313, 88342, 88180, etc., for interpretation of stains, slides or material previously interpreted by another pathologist. CPT codes 88312, 88313 and 88342 may be reported with CPT code 88323 if provider performs and interprets these stains de novo. These codes are not to be used for a face-to-face evaluation of a patient. In the event that a physician provides an evaluation and management service to a patient and, in the course of this service, specimens obtained elsewhere are reviewed as well, this is part of the evaluation and management service and is not to be reported separately. Only the evaluation and management service would be reported.

6. Multiple tests to identify the same analyte, marker, or infectious agent should not be reported separately. For example, it would not be appropriate to report both direct probe and amplified probe technique tests for the same infectious agent.

7. Medicare does not pay for duplicate testing. CPT codes 88342 (immunocytochemistry, each antibody) and 88180 (flow cytometry) should not in general be reported for the same or similar specimens. The diagnosis should be established using one of these methods. The provider may report both CPT codes if both methods are required because the initial method is nondiagnostic

or does not explain all the light microscopic findings. The provider can report both methods utilizing modifier -59 and document the need for both methods in the medical record.

If the abnormal cells in two or more specimens are morphologically similar and testing on one specimen by one method (88342 or 88180) establishes the diagnosis, the other method should not be reported on the same or similar specimen. Similar specimens would include, but are not limited to:

(1) blood and bone marrow;
(2) bone marrow aspiration and bone marrow biopsy;
(3) two separate lymph nodes; or
(4) lymph node and other tissue with lymphoid infiltrate.

8. Quantitative immunohistochemistry by digital cellular imaging should not be reported as CPT code 88342 with CPT code 88358. Prior to January 1, 2004, it should be reported as CPT code 88342. Beginning January 1, 2004, it should be reported as CPT code 88361. CPT code 88361 should not be used to report any service other than quantitative immunocytochemistry by digital cellular imaging. Digital cellular imaging includes computer software analysis of stained microscopic slides.

9. DNA ploidy and S-phase analysis of tumor by digital cellular imaging technique should not be reported as CPT code 88313 with CPT code 88358. Prior to January 1, 2004, it should be reported as CPT code 88313. Beginning January 1, 2004, it should be reported as CPT code 88358. Prior to January 1, 2004, CPT code 88358 should be utilized to report DNA ploidy and S-phase analysis of tumor by non-digital cellular imaging techniques. CPT code 88358 should not be used to report any service other than DNA ploidy and S-phase analysis. One unit of service for CPT code 88358 includes both DNA ploidy and S-phase analysis.

10. CPT code 83721 (lipoprotein, direct measurement; direct measurement, LDL cholesterol) is used to report direct measurement of the LDL cholesterol. It should not be used to report a calculated LDL cholesterol. Direct measurement of LDL cholesterol in addition to total cholesterol (CPT code 82465) or lipid panel (CPT code 80061) may be reasonable and necessary if the triglyceride level is too high to permit calculation of the LDL cholesterol. In such situations, CPT code 83721 should be reported with modifier -59.